



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

INNOVA HOSPITAL SAN ANTONIO  
4243 E SOUTHCROSS BLVD  
SAN ANTONIO TX 78222-3727

#### **Respondent Name**

LIBERTY INSURANCE CORPORATION

#### **Carrier's Austin Representative Box**

Box Number 1

#### **MFDR Tracking Number**

M4-11-1274-01

#### **MFDR Date Received**

December 10, 2010

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The Hospital believes the insurance carrier failed to properly reimburse the hospital fees leaving the Hospital for preauthorized services no choice but to seek medical fee dispute resolution. Further, the insurance carrier failed to properly pay for the pharmaceuticals and other care received by the Claimant and refused without proper justification to pay any of the amounts on a number of services provided."

**Amount in Dispute:** \$11,929.21

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The bill and documentation attached to the medical dispute have been re-reviewed and we do not believe any additional amount is warranted. . . . Liberty Mutual believes that Innova Hospital has been appropriately reimbursed for services rendered . . ."

**Response Submitted by:** Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2009	Outpatient Hospital Services	\$11,929.21	\$2,257.94

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
  - B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED. (B291)
  - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)
  - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
  - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)

### **Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

### **Findings**

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code A4209 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
  - Procedure code S5000 is not a valid Medicare billing code, or was not in effect on the disputed date of service. Pursuant to 28 Texas Administrative Code §134.403(d), which states in pertinent part that "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs. . . . (3) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later," reimbursement cannot be recommended.
  - Procedure code J1040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
  - Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
  - Procedure code Q9949 is not a valid Medicare billing code, or was not in effect on the disputed date of service. Pursuant to 28 Texas Administrative Code §134.403(d), which states in pertinent part that "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is

provided with any additions or exceptions specified in this section, including the following paragraphs. . . . (3) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later,” reimbursement cannot be recommended.

- Procedure code A4649 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
  - Procedure code 81025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.24. 125% of this amount is \$11.55. The recommended payment is \$11.55.
  - Procedure code 64483 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0207, which, per OPPS Addendum A, has a payment rate of \$473.78. This amount multiplied by 60% yields an unadjusted labor-related amount of \$284.27. This amount multiplied by the annual wage index for this facility of 0.8913 yields an adjusted labor-related amount of \$253.37. The non-labor related portion is 40% of the APC rate or \$189.51. The sum of the labor and non-labor related amounts is \$442.88. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider’s CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare’s OPPS Annual Policy Files. Medicare lists the Urban Texas 2009 Default CCR as 0.2379. This ratio multiplied by the billed charge of \$4,900.00 yields a cost of \$1,165.71. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of \$442.88 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$1,871.43. The allocated portion of packaged costs is \$1,871.43. This amount added to the service cost yields a total cost of \$3,037.14. The cost of this service exceeds the annual fixed-dollar threshold of \$1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is \$2,262.10. 50% of this amount is \$1,131.05. The total APC payment for this service, including outliers, is \$1,573.93. This amount multiplied by 200% yields a MAR of \$3,147.86.
  - Procedure code D9215 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
4. The total allowable reimbursement for the services in dispute is \$3,159.41. This amount less the amount previously paid by the insurance carrier of \$901.47 leaves an amount due to the requestor of \$2,257.94. This amount is recommended.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$2,257.94.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2,257.94, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

## **Authorized Signature**

\_\_\_\_\_  
Signature

Grayson Richardson  
Medical Fee Dispute Resolution Officer

September 28, 2012  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**